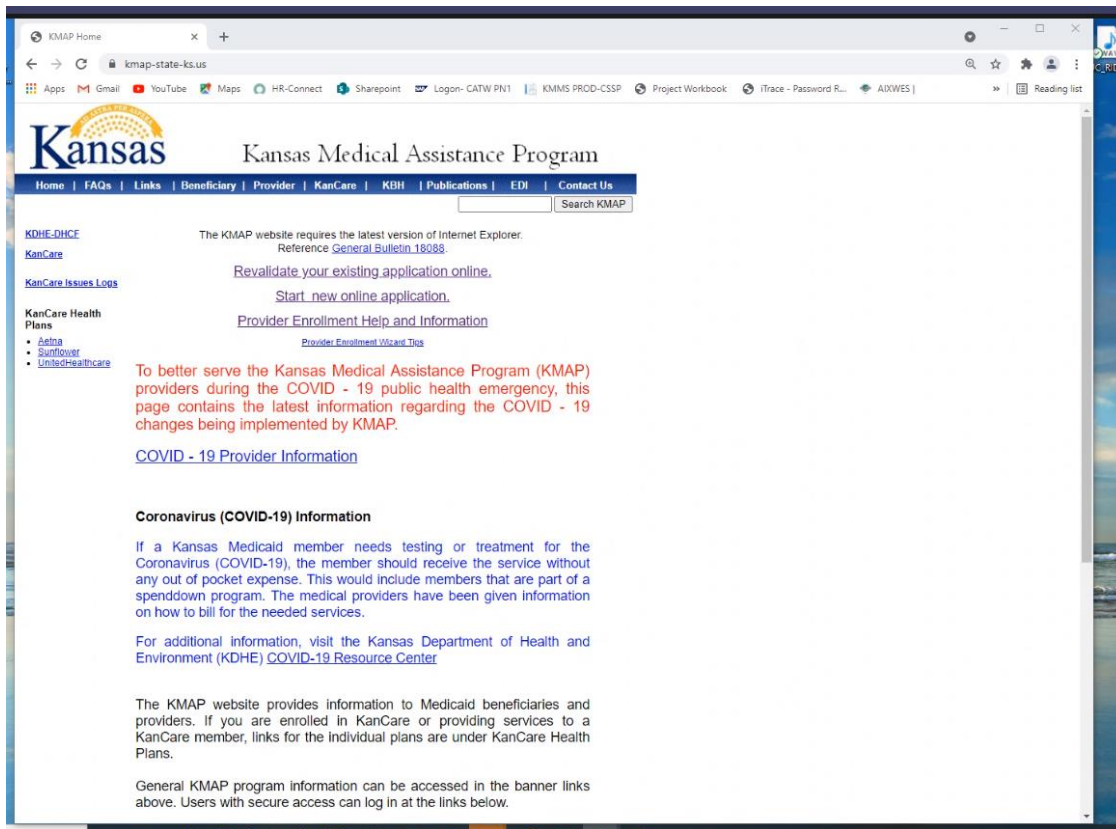
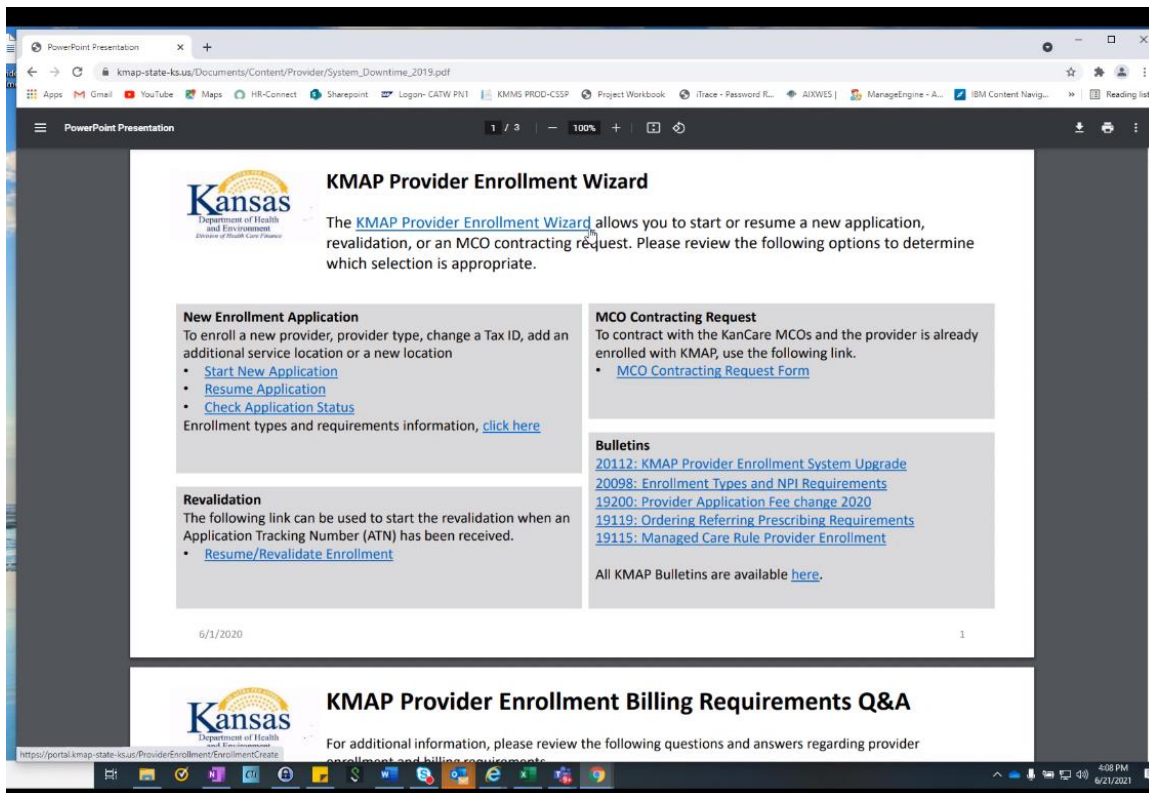


# Kansas Medical Assistance Program SIA Application: Step-by-step guide

Go to [www.kmap-state-ks.us](http://www.kmap-state-ks.us) Click: Start new application



Click START, or Resume application



## Enrollment Pre-Checklist

Enrollment Type: Facility; Provider Type: Hospital; Specialty: 019- State Mental Hospital

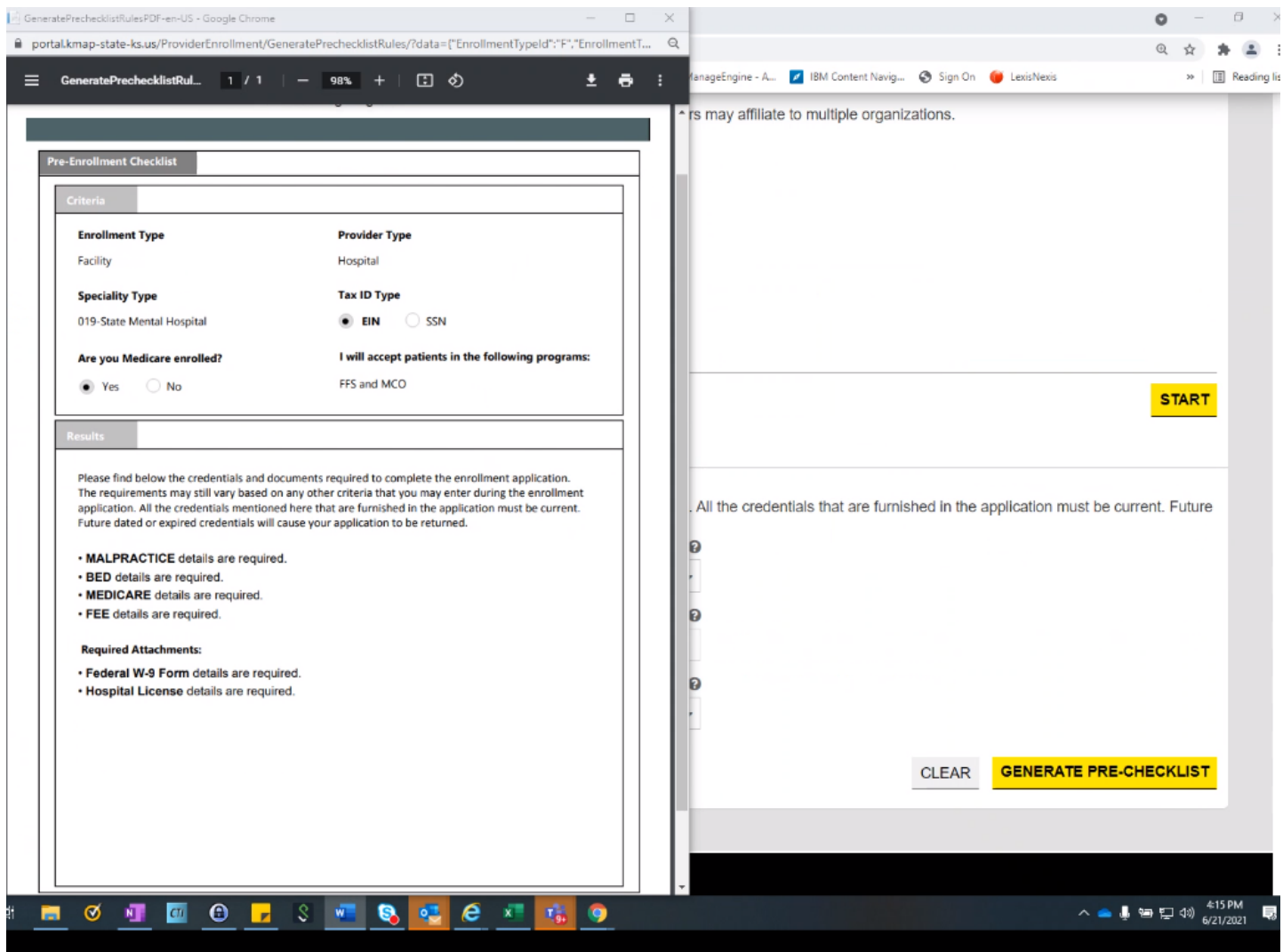
NOTE: The Enrollment Type and Provider Type are not changeable. If you choose the wrong type for either, the application will not be useable, and you will need to start a new application.

Effective date can be back dated if needed.

Are you Medicare enrolled: Yes ( if you click No- it will not allow you to more forward at #7)

Tax ID Type: EIN; I will accept patients in the following programs: FFS and MCO; Click: Generate Pre-checklist

See below for the information and documents that you will be required to provide to complete your application. Have them ready to move on.



Start application, it will ask you to register your account.

Provide your email and create a password. If you are enrolling more than one location – fill out the provider reference box. It will allow you to distinguish between the multiple applications you are submitting.

New Enrollment

portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentCreate#

DXC technology DXC Medicaid Healthcare Payer Platform

MENU Provider Enrollment New Enrollment

**Registration**

Register below to be assigned a unique enrollment tracking number. Be sure to write down your password. An email confirmation will be sent with the tracking number. If you don't submit your enrollment right away, you can use this tracking number and password to resume your enrollment application later.

\* Email  \* Confirm Email

\* Password  \* Confirm Password

Provider Reference

Click on KMAP Provider Enrollment Wizard or Start New Application

New Enrollment

portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentCreate

DXC technology DXC Medicaid Healthcare Payer Platform

Mon Jun 21, 4:09 PM

Contact Us

MENU Provider Enrollment New Enrollment

**Welcome**

Welcome to the Online Provider Enrollment System

To start a NEW application please click the "Start" button in the bottom right corner to begin the enrollment process. The application will automatically save each time you click "Continue".

To RESUME an application click [Here](#)

To start a REVALIDATION click [Here](#)

To check the STATUS of an application click [Here](#)

**MCO Contracting Request**

To ADD an MCO to an already enrolled provider click [Here](#)

Please note that only one service location and one provider type can be enrolled per application. All attachments must be complete, legible and current. You will be notified if your application cannot be processed because it is incomplete or the information is incorrect.

Existing Group members (Individuals in a Group) only need to be enrolled once for each state in which they practice. Individual in a Group providers may affiliate to multiple organizations.

All providers may need the following minimum information to complete your enrollment request:

- Address information
- Tax Identification Number/Social Security Number
- W-9
- Application Fee

Additional information may also be required depending on provider type such as:

- National Provider Identifier
- Taxonomy code(s)
- License Number(s) and Effective Dates
- CLIA Number and Effective Dates – if billing laboratory codes

For general enrollment Frequently Asked Questions, click [Here](#)

For any questions related to your application, call 800-933-6593.

**START**

**Enrollment Pre-Checklist**

The next page will have a bar at the top of the page with 13 steps you will need to complete; it will show your progress through the application:



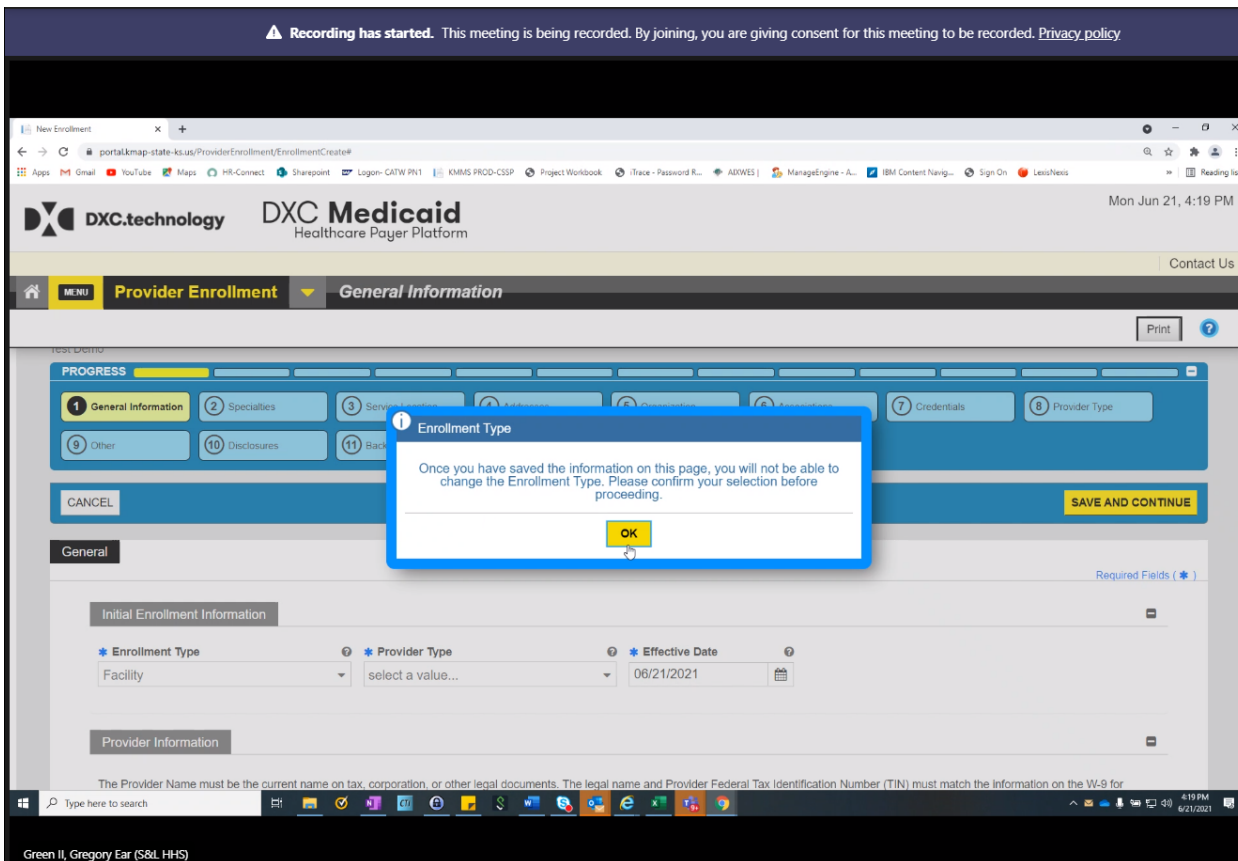
#1 General Information. IT is important to choose correct options – after moving past page 1 you will not be able to change the Enrollment Type or Provider Type.

Enrollment Type: Facility

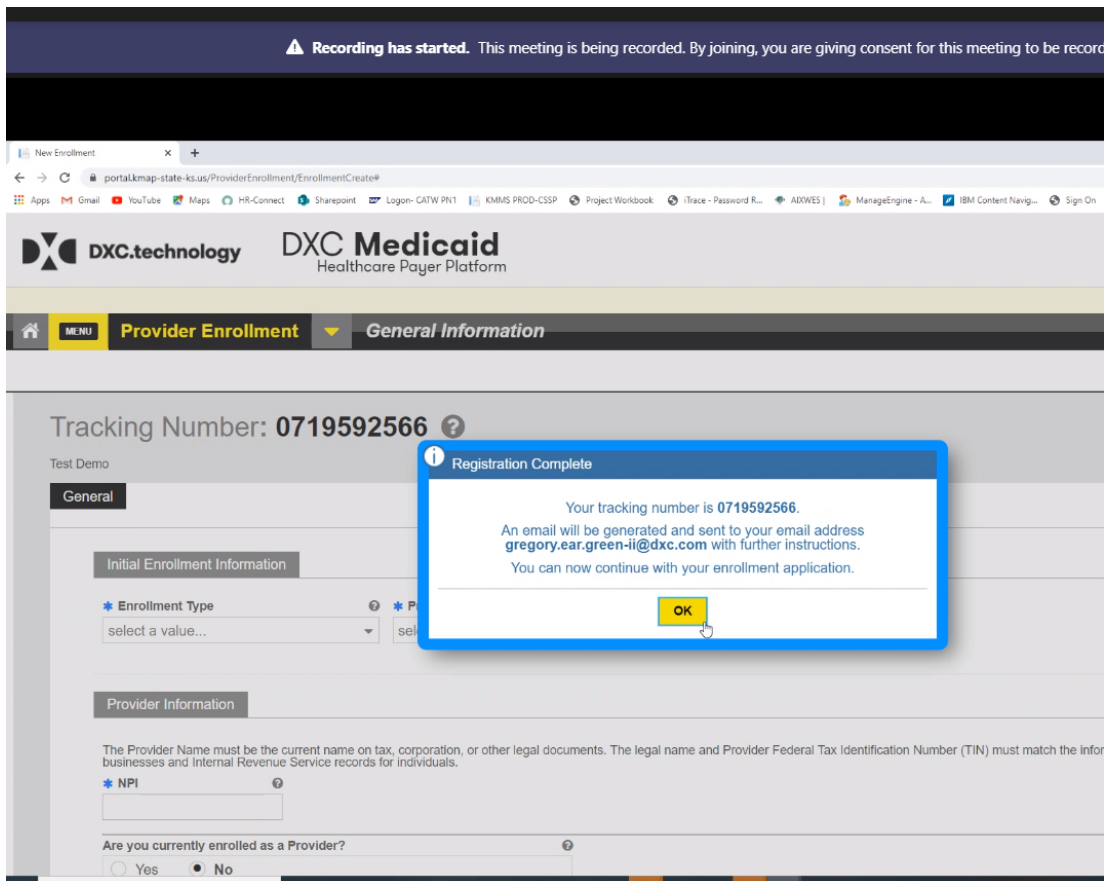
Provider Type: Hospital

Specialty: 019- State Mental Hospital

Choose the date you want to be active (the date you are filling out the application) and it can be backdated as well.



Once you click save and continue on the previous page, you will receive an email with the tracking number



#### New Enrollment Registration Notification

 Kansas-Provider-Enrollment@dxcc.com  
To: Green II, Gregory Ear (S&L HH5)  
if there are problems with how this message is displayed, click here to view it in a web browser.

[Reply](#) [Reply All](#) [Forward](#) [...](#)  
Mon 5/21/2021 4:18 PM

Congratulations! You have successfully registered for your provider enrollment application with the Kansas Medical Assistance Program. Below is your tracking number that has been associated with your enrollment application. If you have not submitted your application, it will remain valid for 30 days from the last time you updated it.

Tracking Number: 0719592566  
Password: S\*\*\*\*\*1

Provider Reference: Test Demo

To resume your partially completed enrollment, simply access the site at the address below and enter your enrollment tracking number and the password you entered during the registration process.

<https://portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentResume/>

If you have any questions or concerns, please contact Provider Enrollment at your earliest convenience.

Sincerely,

Kansas Medical Assistance Program  
Provider Enrollment  
[Kansas-Provider-Enrollment@dxcc.com](mailto:Kansas-Provider-Enrollment@dxcc.com)  
Contact us: 1-800-933-6593

Fill out your Provider Information



You will need to select Yes for the “Are you Medicare enrolled?” question, or you will not be able to get past # 7 in the application as it will require you to provide your Medicare number.

Select FFC and MCO

Recording has started. This meeting is being recorded. By joining, you are giving consent for this meeting to be recorded. [Privacy policy](#)

New Enrollment

portal.kmap.state-ks.us/ProviderEnrollment/EnrollmentCreate#

Apps Gmail YouTube Maps HR-Connect Sharepoint Logon- CATW PNT KMMS PROO-CSSP Project Workbook Trace - Password R... ADWES | ManageEngine - A... IBM Content Navig... Sign On Less/News Reading list

Enrollment Type Facility Provider Type Hospital Effective Date 06/21/2021

Provider Information

The Provider Name must be the current name on tax, corporation, or other legal documents. The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9 for businesses and Internal Revenue Service records for individuals.

Legal Name UnityPoint Health - Marshalltown Tax Name Doing Business As Name NPI 1629503057

EIN 31 111 1111

Are you currently enrolled as a Provider?  
☐ Yes ☒ No

Were you previously enrolled as a Provider?  
☐ Yes ☒ No

Are you Medicare enrolled?  
☒ Yes ☐ No

If you choose "FFS and MCO" or "MCO (s) only", your information will be shared with the selected MCO programs. This application does not guarantee participation with the Managed Care Organizations. Each organization is independent. Please select the appropriate option.

I will accept patients in the following programs:  
select a value...

Please select the programs to which you are applying. You must choose at least one.  
Select a Program

Are you registered with CAQH?

Select MCOs you would like to select. You can select 1, 2 or all 3

Select no for CAQH question

New Enrollment

portal.kmap.state-ks.us/ProviderEnrollment/EnrollmentCreate#

Apps Gmail YouTube Maps HR-Connect Sharepoint Logon- CATW PNT KMMS PROO-CSSP Project Workbook Trace - Password R... ADWES | ManageEngine - A... IBM Content Navig... Sign On Less/News Reading list

Were you previously enrolled as a Provider?  
☐ Yes ☒ No

Are you Medicare enrolled?  
☒ Yes ☐ No

If you choose "FFS and MCO" or "MCO (s) only", your information will be shared with the selected MCO programs. This application does not guarantee participation with the Managed Care Organizations. Each organization is independent. Please select the appropriate option.

I will accept patients in the following programs:  
FFS and MCO

Please select the programs to which you are applying. You must choose at least one.  
AETNA BETTER HEALTH OF KS INC. X SUNFLOWER HEALTH PLAN X UNITED HEALTH CARE COMMUNITY PLAN X

Are you registered with CAQH?  
☐ Yes ☒ No

## Provide Contact Information

The screenshot shows a web browser window with the URL `portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentCreate#`. The page title is "New Enrollment". Below the browser window, there is a form with the following elements:

- A message: "Please select the programs to which you are applying. You must choose at least one." Below this, three programs are selected: "AETNA BETTER HEALTH OF KS INC.", "SUNFLOWER HEALTH PLAN", and "UNITED HEALTH CARE COMMUNITY PLAN".
- A question: "Are you registered with CAQH?" with radio buttons for "Yes" and "No".
- A "Contact Information" section with the following fields:
  - Title
  - Address Line 1: "6511 SE Forbes Ave"
  - City: "Topeka"
  - Phone Type: "select a value..."
  - Email Address
  - Preferred Communication: "select a value..."
- A "CANCEL" button at the bottom left.

A "Search Address" modal is open over the form. It contains a table with the following data:

Number	Street	City	County	State	Country	ZIP Code
6511	SE FORBES AVE	TOPEKA	SHAWNEE	KS	UNITED STATES	66619-1448

Email is required even though there is no asterisk. Email is always a preferred method of communication

The screenshot shows the same "New Enrollment" form, but with the "Email Address" field highlighted in yellow. The form now includes the following fields:

- Title
- Last Name: "Green"
- First Name: "Gregory"
- Middle Name
- Suffix
- Address Line 1: "6511 SE FORBES AVE"
- Address Line 2
- City: "TOPEKA"
- State: "Kansas"
- Country: "United States"
- ZIP Code: "66619-1448"
- Phone Type: "Home"
- Phone Number: "785-555-5555"
- Extension
- Fax Number
- Email Address: "greg" (highlighted in yellow)
- Confirm Email

Below the "Email Address" field, there is a dropdown menu showing the email address "gregory.ear.green-ii@dx.com" and the address "2637 SE Virginia AVE". A "Manage addresses..." link is also visible.

#2 Specialties. Create New. Select 019- State Mental Hospital and make it Primary.



## Taxonomy- Hospitals/Psychiatric hospital

CANCEL

PREVIOUS

SAVE AND CONTINUE

Specialties

Required Fields ( \* )

Specialties

The provider type selected on the previous page determines the specialties available. One specialty must be named as primary.

Provider Type

Hospital

CREATE NEW

Specialty	Taxonomy	Waiver/Entitlement Type	Primary	Effective Date	Edit
-----------	----------	-------------------------	---------	----------------	------

Additional Taxonomies

CANCEL

PREVIOUS

SAVE AND CONTINUE

Specialties

Required Fields ( \* )


Specialties

The provider type selected on the previous page determines the specialties available. One specialty must be named as primary.

Provider Type

Hospital

CREATE NEW

Specialty	Taxonomy	Waiver/Entitlement Type	Primary	Effective Date	Edit
019-State Mental Hospital	283Q00000X-Hospitals/Psychiatric Hospital		x	6/21/2021	

Additional Taxonomies

**New Specialty**

Required Fields ( \* )

☒ **Make Primary**

**\* Specialty**  
019-State Mental Hospital

**\* Effective Date**  
06/21/2021

**\* Taxonomy**  
283Q00000X - Hospitals/Psychiatric Hospital

**CANCEL** **SAVE**

To add more taxonomies- click edit. For SIA enrollment – you will need one only

Save and Continue

**DXC Medicaid**  
Healthcare Payer Platform

Mon Jun 21, 4:36 PM

**Provider Enrollment** **Specialties**

**Additional Taxonomies**

Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty.

Taxonomy	Actions
283Q00000X - Hospitals/Psychiatric Hospital	<b>Edit</b>

**CREATE NEW**

**Print**

Step #3 Service Location. Create new

Service Location

portal&map-state-ks.us/ProviderEnrollment/EnrollmentServiceLocation/

DXC.technology DXC Medicaid Healthcare Payer Platform

Mon Jun 21, 4:37 PM

Provider Enrollment Service Location

Print

### Step 3: Service Location - Tracking Number: 0719592566 ?

Step 3 of 13

Test Demo

PROGRESS

1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization 6 Associations 7 Credentials 8 Provider Type

9 Other 10 Disclosures 11 Attachments 12 Fees 13 Agreement / Submit

CANCEL PREVIOUS SAVE AND CONTINUE

Service Location

Required Fields ( \* )

Service Location

CREATE NEW

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
---------------	----------------	----------------	------	-------	---------	------

Provide details; Save and Continue

Recording has started. This meeting is being recorded. By joining, you are giving consent for this meeting to be recorded. [Privacy policy](#)

Service Location

portal&map-state-ks.us/ProviderEnrollment/EnrollmentServiceLocation/

DXC.technology DXC Medicaid Healthcare Payer Platform

Mon Jun 21, 4:39 PM

Provider Enrollment Service Location

Print

### Step 3: Service Location - Tracking Number: 0719592566 ?

Step 3 of 13

Test Demo

PROGRESS

1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization 6 Associations 7 Credentials 8 Provider Type

9 Other 10 Disclosures 11 Attachments 12 Fees 13 Agreement / Submit

CANCEL PREVIOUS SAVE AND CONTINUE

Service Location

Required Fields ( \* )

Service Location

CREATE NEW

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
---------------	----------------	----------------	------	-------	---------	------

CANCEL PREVIOUS SAVE AND CONTINUE

Green II, Gregory Ear (S&L HHS)

**Recording has started.** This meeting is being recorded. By joining, you are giving consent for this meeting to be recorded. [Privacy policy](#)

Service Location x +

portal.kmap.state-ks.us/ProviderEnrollment/EnrollmentServiceLocation/

Apps Gmail YouTube Maps HR-Connect Sharepoint Logon- CATW PN1 KMMS PROD-CSSP Project Workbook iTrace - Password R... ADXWES ManageEngine - A... IBM Content Navig... Sign On Less/More

1 General Information 2 Service Location 3 Other 4 Disclosures 5 Attachments 6 Fees 7 Agreement / Submit

CANCEL

Service Location

Location Name

**New Service Location**

Required Fields (\*)

☒ Make Primary

Please complete all the required fields under the Service Location address. This will allow you to copy the address to the other address types. Note that copied addresses cannot be edited.

\* Location Name  
UnityPoint Health - Marshal

Contact Information

\* Last Name \* First Name \* Middle Name \* Suffix  
Green Gregory Earl Earl

\* Address Line 1 \* Address Line 2 \* Country \* State  
6511 SE FORBES AVE United Kansas

\* City \* County \* ZIP Code \* Location Code  
TOPEKA Shawnee 66619-1448 In State

Email \* Confirm Email  
gregory.ear.green-ii@dxc.com gregory.ear.green-ii@dxc.com

Phone Number

At least one Phone Number must be provided.

CREATE NEW

To add a phone number- slick Create new and add a phone number, save and select hours of operation, create new and select the hours, click Save

6/ProviderEnrollment/EnrollmentServiceLocation/

ps HR-Connect Sharepoint Logon- CATW PN1 KMMS PROD-CSSP Project Workbook iTrace - Password R... ADXWES ManageEngine - A... IBM Content Navig... Sign On

10 Disclosures 11 Attachments 12 Fees 13 Agreement / Submit

location

Name

**New Service Location**

Day	From Hour	To Hour	Edit
EveryDay	24 Hours		

\* Is the service location ADA compliant?  
☒ Yes ☐ No

\* Is the service location accessible by public trans...  
☒ Yes ☐ No

\* What are your after-hour arrangements?  
I

8-5 Emergency Phone N... Extension  
select a 7856082490

CANCEL SAVE

Service Location

portal.kmap-state-ks.us/ProviderEnrollment/Enrollment/ServiceLocation/

Other 10 Disclosures 11 Attachments 12 Fees 13 Agreement / Submit

CANCEL PREVIOUS SAVE AND CONTINUE

Service Location

Required Fields (\*)

Service Location

CREATE NEW

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
UnityPoint Health - Marshalltown	6511 SE FORBES AVE		TOPEKA	Kansas	X	

CANCEL PREVIOUS SAVE AND CONTINUE

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Green II, Gregory Ear (S&L, HHS)

Step #4 Addresses. Click Same as Service Location to autofill or provide other details manually

Addresses

portal.kmap-state-ks.us/ProviderEnrollment/Addresses/

Addresses

Pay To

You may enter the Pay To address information only after completing all the required fields for the Service Location address.

☒ Same as Service Location

\* Location Name  
UnityPoint Health - Marshalltown

Contact Information

\* Last Name  
green

\* First Name  
Gregory

\* Middle Name

\* Suffix

\* Billing Agent Name

\* Address Line 1  
6511 SE FORBES AVE

\* Address Line 2

\* City  
TOPEKA

\* State  
Kansas

\* Country  
United States

\* ZIP Code  
66619-1448

☐ Same as Service Location

Email

Confirm Email

Phone Number

☒ Same as Service Location

Email  
 gregory.ear.green-ii@dx.com

Confirm Email  
 gregory.ear.green-ii@dx.com

Phone Number

At least one Phone Number must be provided.

Phone Type	Phone Number	Extension	Edit
Home	785-555-5555		

Mail To

You may enter the Mail To address only after completing all the required fields for the Service Location address.

Same as  
 Service Location

Location Name  
 UnityPoint Health - Marshalltown

Contact Information

Last Name  
 green

First Name  
 Gregory

Middle Name

Suffix

Address Line 1  
 6511 SE FORBES AVE

Address Line 2

City  
 TOPEKA

State  
 Kansas

Country  
 United States

ZIP Code  
 66619-1448

Same as  
 Service Location

Preferred Communication  
☒ Mail ☐ Email

Email  
 gregory.ear.green-ii@dx.com

Confirm Email  
 gregory.ear.green-ii@dx.com

Phone Number

Information below is Optional: Informational Mail Address; Remit TO; Doing Business as; Medical Records Request

47:58

Recording has started. This meeting is being recorded. By joining, you are giving consent for this meeting to be recorded. [Privacy policy](#)

Addresses

portal.kmap-state-ks.us/ProviderEnrollment/Addresses/

At least one Phone Number must be provided.

Phone Type	Phone Number	Extension	Edit
Home	785-555-5555		

Informational Mail Address

Remit To

Doing Business As

Medical Records Request

CANCEL

PREVIOUS

SAVE A



## # 5 Organizational Details.

50:19

**Recording has started.** This meeting is being recorded. By joining, you are giving consent for this meeting to be recorded. [Privacy Policy](#)

Organization

portal.kmap-state-ks.us/ProviderEnrollment/Organization/

Apps | Gmail | YouTube | Maps | HR-Connect | Sharepoint | Logon- CATW PNT | KMMS PROD-CSSP | Project Workbook | iTrace - Password R... | ADXWES | ManageEngine - A... | IBM Content Navig... | Sign On | LexisNexis

### Organizational Details

If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.

If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.

**\* Organization Type** ⓘ  
Not for Profit

**\* Tax Classification** ⓘ  
OTHER

Entities doing business in the State, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. For more information on the registration process, please go to the Secretary of State website at <https://www.dxc.technology/healthcare/>

☐ Registered with Secretary Of State ⓘ

☐ Incorporated ⓘ

☐ Chain Affiliated ⓘ

☐ Operated by Management Company ⓘ

☐ Domestic Owned Corporation ⓘ

☐ Foreign Owned Corporation ⓘ

**Business Start Date** ⓘ  
[Calendar Icon]

**Incorporation Date** ⓘ  
[Calendar Icon]

Green II, Gregory Ear (S&H, HHS)

Next part is optional:

Entities doing business in the State, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. For more information on the registration process, please go to the Secretary of State website at <https://www.dxc.technology/healthcare/>

☐ Registered with Secretary Of State ⓘ

☐ Incorporated ⓘ

☐ Chain Affiliated ⓘ

☐ Operated by Management Company ⓘ

☐ Domestic Owned Corporation ⓘ

☐ Foreign Owned Corporation ⓘ

**Business Start Date** ⓘ  
[Calendar Icon]

**Incorporation Date** ⓘ  
[Calendar Icon]

CANCEL PREVIOUS **SAVE AND CONTINUE**

#6 Associations – Will be left blank

#7 Credentials. For instate Kansas providers- leave blank or it will ask you to fill out details. IF you accidentally click new one- use dummy info

The screenshot shows a web application interface for managing credentials. It has two main sections: 'License' and 'Medicare Participation'. Each section has a 'CREATE NEW' button and a table with columns for various fields. The 'License' table has columns: License Number, Issuing State, Issuing Board, Effective Date, End Date, and Edit. The 'Medicare Participation' table has columns: Medicare Number, Medicare Type, Effective Date, End Date, Consider for Medicare Crossover, and Edit. The browser's address bar shows the URL: portal.kmap-state-ks.us/ProviderEnrollment/CredentialInformation/.

MEDICARE Participation is required

This screenshot shows the 'Medicare Participation' section of the web application. A modal window titled 'New Medicare Participation' is open, displaying a form with the following fields: 'Consider for Medicare Crossover Claims' (checkbox), 'Medicare Number' (text input with value '160001'), 'Medicare Type' (dropdown menu with value 'Medicare Part A'), 'Effective Date' (calendar input with value '06/21/2021'), and 'End Date' (calendar input with value '06/30/2021'). The modal also includes 'CANCEL' and 'SAVE' buttons. The background shows the 'Medicare Participation' table and a 'Medicaid Program' section with a question: 'Are you enrolled in other state Medicaid programs? If so, please indicate which states.' with 'Yes' and 'No' radio buttons.

If you are not participating in another State Medicaid program- select No

Medicaid Program

Are you enrolled in other state Medicaid programs? If so, please indicate which states.

☐ Yes ☒ No

DEA

CREATE NEW

DEA Number	Effective Date	End Date	Edit
------------	----------------	----------	------

Leave CLIA information blank

Bed information: create new.

Bed Information

CREATE NEW

Bed Type	Number Of Beds	Effective Date	End Date	Edit
----------	----------------	----------------	----------	------

Level of Maternal Care

For psych hospitals only – only choose psych beds

Provider Type Information

CLIA

CREATE NEW

CLIA Number	CLIA Type	Effective Date	End Date	Edit
-------------	-----------	----------------	----------	------

New Bed Information

Required Fields (\*)

Bed Type: General Beds  
Number Of Beds: 10  
Effective Date: 06/21/2021  
End Date: 06/30/2021

CANCEL SAVE

Bed Information

CREATE NEW

Bed Type	Number Of Beds	Effective Date	End Date	Edit
----------	----------------	----------------	----------	------

## # 9 Languages, Certification, Additional info and malpractice information

### Additional Information

Please enter the provider website address below. It must begin with "http:" or "https:" followed by a valid address.

Provider Website URL

### Malpractice Information

Please complete the malpractice information below

CREATE NEW

Type of Carrier	Name of Carrier	Coverage Amount Ag...	Coverage Amount Pe...	Policy Number	Effective Date	End Date	Edit
Professional Liability	Blue Cross	10000	10000	111111111111	6/21/2021	6/30/2021	

Are you currently or have you within the last ten years been involved in a malpractice suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit?

☐ Yes ☐ No

## # 10 Disclosures. Fill out each of the following by clicking Create NEW: Provider Self Disclosure; Sub-Contractor Disclosure; Ownership and Control Interest; Managing employees; Business Transaction

01:02:37

Request of

Recording has started. This meeting is being recorded. By joining, you are giving consent for this meeting to be recorded. [Privacy policy](#)

Disclosures

portal.kmap.state-ks.us/ProviderEnrollment/Disclosures/

Apps Gmail YouTube Maps HR-Connect Sharepoint Logon- CATW PNT KMMS PROD-CSSP Project Workbook Trace - Password R... AIRWES ManageEngine - A... IBM Content Navig... Sign On LexisNexis

Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the State Medical Assistance Program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation. Any information may also be provided to the U.S. DHHS Centers for Medicare and Medicaid Services, the Internal Revenue Service, State Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state or local agencies as appropriate.

Providing this information is mandatory to be eligible to enroll as a provider with the State Medical Assistance Program, pursuant to 42 CFR § 455 and CFR § 438. Failure to submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the State Medical Assistance Program.

OWNERSHIP/CONTROLLING INTEREST

Federal law requires individuals and entities with ownership, control, management or a business relationship to submit a separate disclosure form for each entity or person affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 106, 42 CFR § 455.436, 42 CFR § 1002.3, and CFR § 438.602 (b)

DISCLOSURE FORMS

Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please provide the additional information that may be requested.

Disclosure Form	Status	Create New
Provider Self Disclosure	New	<a href="#">CREATE NEW</a>
Sub-Contractor Disclosure	New	<a href="#">CREATE NEW</a>
Ownership and Control Interest	New	<a href="#">CREATE NEW</a>
Managing Employees	New	<a href="#">CREATE NEW</a>
Business Transaction	New	<a href="#">CREATE NEW</a>

CANCEL

DISCLOSE

SAVE AND CONTINUE

to submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the State Medical Assistance Program.

#### OWNERSHIP/CONTROLLING INTEREST

Federal law requires individuals and entities with ownership, control, management or a business relationship to submit a separate disclosure form for each entity or person affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 106, 42 CFR § 455.436, 42 CFR § 1002.3, and CFR § 438.602 (b)

#### DISCLOSURE FORMS

Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please provide the additional information that may be requested.

Disclosure Form	Status	Create New
Provider Self Disclosure	Completed	<a href="#">CREATE NEW</a>
Sub-Contractor Disclosure	Completed	<a href="#">CREATE NEW</a>
Ownership and Control Interest	Completed	<a href="#">CREATE NEW</a>
Managing Employees	Completed	<a href="#">CREATE NEW</a>
Business Transaction	Completed	<a href="#">CREATE NEW</a>

[CANCEL](#)

[PREVIOUS](#)

[SAVE AND CONTINUE](#)

Any information provided to the State Medical Assistance Program may also be used for Medicaid Fraud Control Unit purposes.

Providing this information to submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the State Medical Assistance Program.

OWNERSHIP/CONTROLLING INTEREST

Federal law requires individuals and entities with ownership, control, management or a business relationship to submit a separate disclosure form for each entity or person affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 106, 42 CFR § 455.436, 42 CFR § 1002.3, and CFR § 438.602 (b)

DISCLOSURE FORMS

Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please provide the additional information that may be requested.

Disclosure Form

Provider Self Disclosure

Sub-Contractor Disclosure

Ownership and Control Interest

Managing Employees

Business Transaction

New Provider Self Disclosure

☐ Yes ☒ NO

General

Is the provider part of a provider or entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act?

☐ Yes ☒ No

Provide the following information for the contact person for audit purposes.

Title

Last Name

First Name

Middle Name

Suffix

Green

Gregory

Address Line 1

Address Line 2

6511 SE Forbes Ave

City

State

Country

ZIP Code

Topeka

Kansas

United States

6511 -

Phone Type

Phone Number

select a

Provide the address for the physical location of the records to be kept under K.A.R. 30-5-59

P.O. Boxes and drop boxes are not acceptable.

Address Line 1

Address Line 2

City

State

Country

ZIP Code

select a value...

select a value...

Phone Type

Phone Number

19

## # 11 Attachments

Upload the documents by going to Details, Create New, transition Method, Attachment. Make sure all the Requirement Met box say: YES

Below are the list of required attachments. Please submit all of the required documentation to continue with the enrollment.

Attachment Type	Requirement Met
Federal W-9 Form	YES
Hospital License	YES
Accreditation Attachment ( AASM, AAAHC, AAAASF, ABC, ACHC, ACR, AOA, ASDA, BOC Int'l, CABG, CACH, CAP, CARF, CCAC, CHAP, COA, COLA, CORF, ABPCO, DNV, HCU, HFAP, HQAA, IAC, NABP, NBAOS, TJC, NCQA, URAC JCAHO/ TJC, AOA, AAAHC, HFAP, ACHC, CHAP, DNV, COA, CAH, DNV, CARF, ABPCO, NCQA, URAC, Other: (if any)	YES
Copy of Declaration Sheet and/ or Certificate of Insurance (Professional Malpractice and Comprehensive General Liability Insurance Policies)	YES

Attachment Details

Transmission Method	Attachment Type	File Name	Edit
File Transfer	Accreditation Attachment ( AASM, AAAHC, AAAASF, ABC, ACHC, ACR, AOA, ASDA, BOC Int'l, CABG, CACH, CAP, CARF, CCAC, CHAP, COA, COLA, CORF, ABPCO, DNV, HCU, HFAP, HQAA, IAC, NABP, NBAOS, TJC, NCQA, URAC JCAHO/ TJC, AOA, AAAHC, HFAP, ACHC, CHAP, DNV,	Workflow Notes for Individuals Within a group v3 (2).docx	

CREATE NEW

## #12 Application Fees.

As of 6/22/2021 the fees are waved due to COVID, but fees are going back into effect.

Please Answer all questions. If you answer "NO" to all the questions below, then you must pay an application fee.

**Application Fee Questions**

**Service Location** - If the service location is enrolled in Medicare a fee payment is not required.

1. Is the service location enrolled in Medicare?

☒ Yes ☐ No

**Medicaid Program** - If the service location has paid an application fee to another Medicaid program then a fee payment is not required.

2. Have you paid an application fee to another state's Medicaid program for the service location?

☒ Yes ☐ No

**Waiver Received** - If you have received a waiver from the programs mentioned below a fee payment is not required.

3. Have you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship?

☐ Yes ☒ No



## Click Proceed

01:12:09 Request control

**Recording has started.** This meeting is being recorded. By joining, you are giving consent for this meeting to be recorded. [Privacy policy](#)

Submit

Aetna Better Health of KS Inc. - <https://www.aetnabetterhealth.com/kansas>  
Sunflower Health Plan - <https://www.sunflowerhealthplan.com>  
United Health Care Community Plan - <https://www.uhc.com>

**Terms of Agreement**

Legal Name	Contact Name	Contact Email
UnityPoint Health - Marshalltown	Gregory Green	gregory.ear.green-ii@dx.com
NPI	Tax ID Type	Tax ID Number
1629503057	EIN	31-1111111
Service Location		
6511 SE FORBES AVE TOPEKA KS, 66619-1448		

The above provider agrees to participate in the Medicaid Program, hereinafter referred to as the Title XIX Program.

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the State Medical Assistance Program.

I understand that I should be enrolled as a provider of services under the State Medical Assistance Program, that it is my responsibility to notify the State Medical Assistance Program fiscal agent of any change to the information on this application including but not limited to address, group affiliation, change of ownership, or tax identification number.

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

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Green II, Gregory Ear (S&L HH5)

## Click YES to agree

**Recording has started.** This meeting is being recorded. By joining, you are giving consent for this meeting to be b

Submit

portalkmap-state-ks-us/ProviderEnrollment/Submit/

The above provider agrees to participate in the Medicaid Program, hereinafter referred to as the Title XIX Program.

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true, the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the Assistance Program.

I understand that I should be enrolled as a provider of services under the State Medical Assistance Program, that it is my responsibility to notify the Assistance Program fiscal agent of any change to the information on this application including but not limited to address, group affiliation, change of identification number.

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

Please read the [Provider Agreement](#) in document b

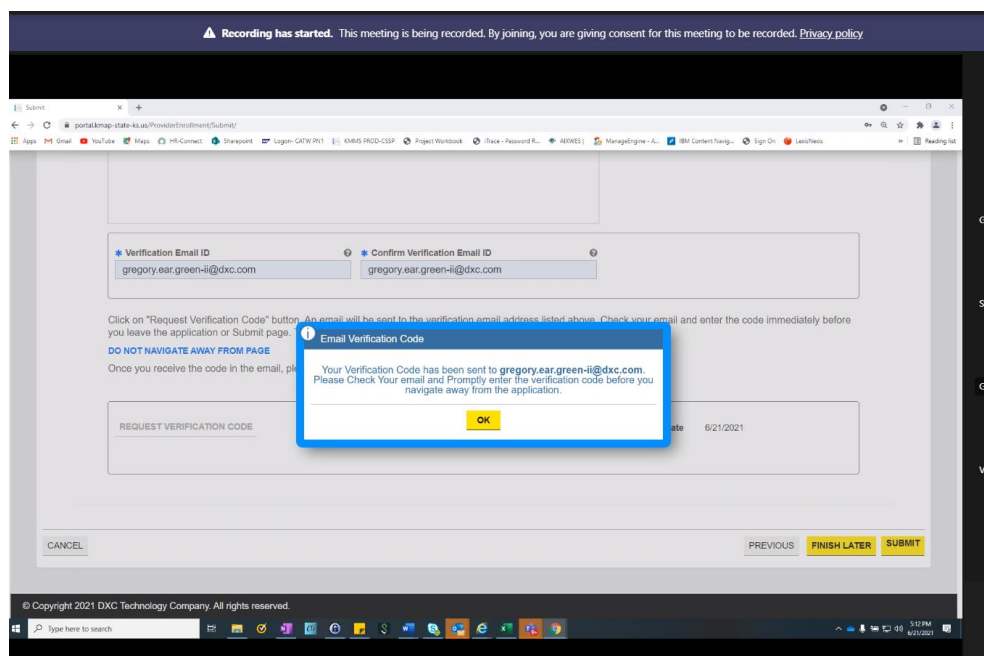
I certify my signature, under my penalty of perjury, agreement and that I have read and understood t

**Agreement Confirmation**

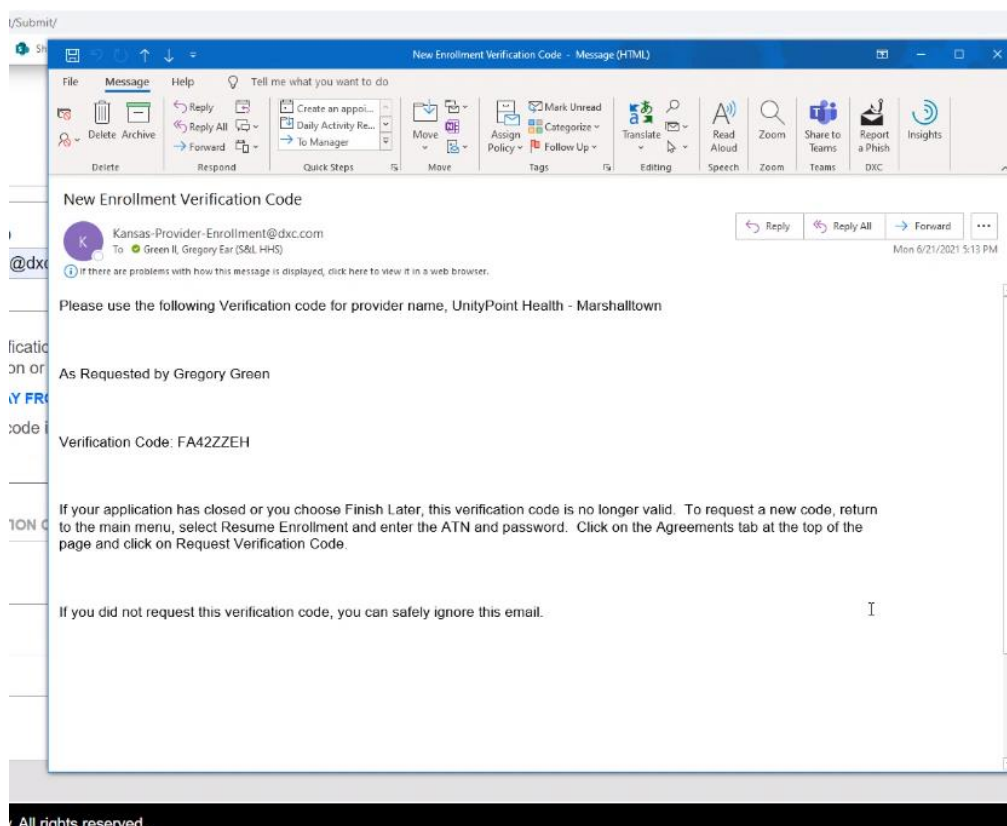
By clicking "Yes" you agree to the terms and conditions of the provider agreement

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## Accept, sign and Request Verification code



## You will receive an email



Plug in the code from the email and Submit the application.

Congratulations! Your application has been submitted. Please let KDADS know that the application has been submitted, provide the MCOs that you have selected along with the application #s.

THANK YOU